

**Health Partners of Kansas
Provider Nomination Form**

**Please complete and return this form to:
Health Partners of Kansas
Provider Credentialing
550 N. Lorraine
Wichita, Ks. 67214
Phone: (316) 652-1327 or (800) 633-9917
Fax: (316) 652-1345**

Provider Information

Name of Provider: _____
Clinic or Facility Name: _____
Specialty: _____
Address: _____
City, State, Zip: _____
Phone Number: _____
Office Contact Name: _____

Member Information

Name of Member/Employee: _____
Patient Name: _____
Employer: _____
Human Resource Contact: _____
Phone Number: _____

We will make every effort to contact the above provider with your request that he/she become a member of the Health Partners of Kansas provider network. Submission of this form to Health Partners of Kansas does not guarantee participation by any provider.